

HEALTH MANAGEMENT ASSOCIATES

Managed Care and Individuals with Intellectual and
Developmental Disabilities:

Innovative Approaches to Care Coordination

Speaker:

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HMA Information Services Webinar

HealthManagement.com

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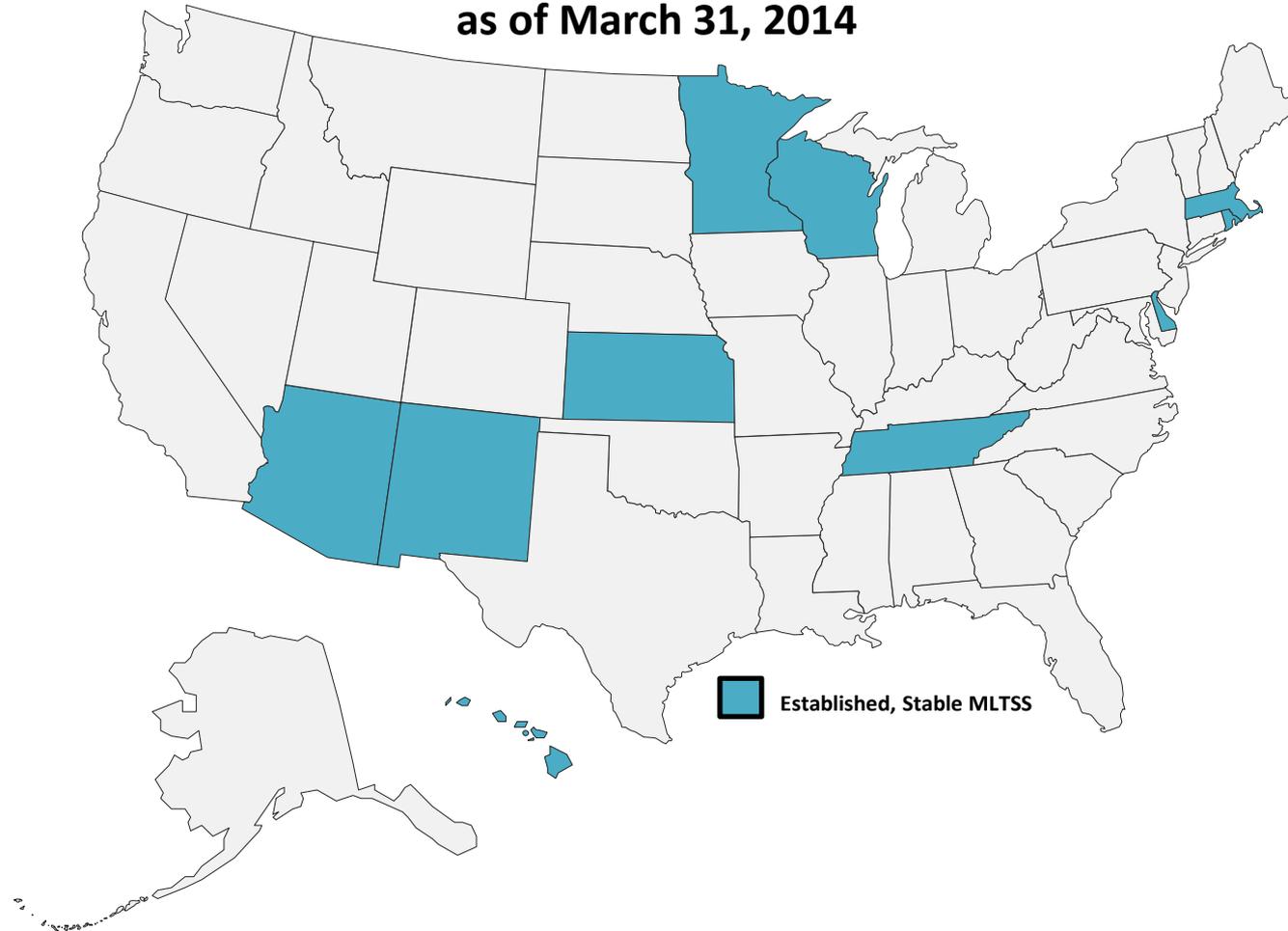
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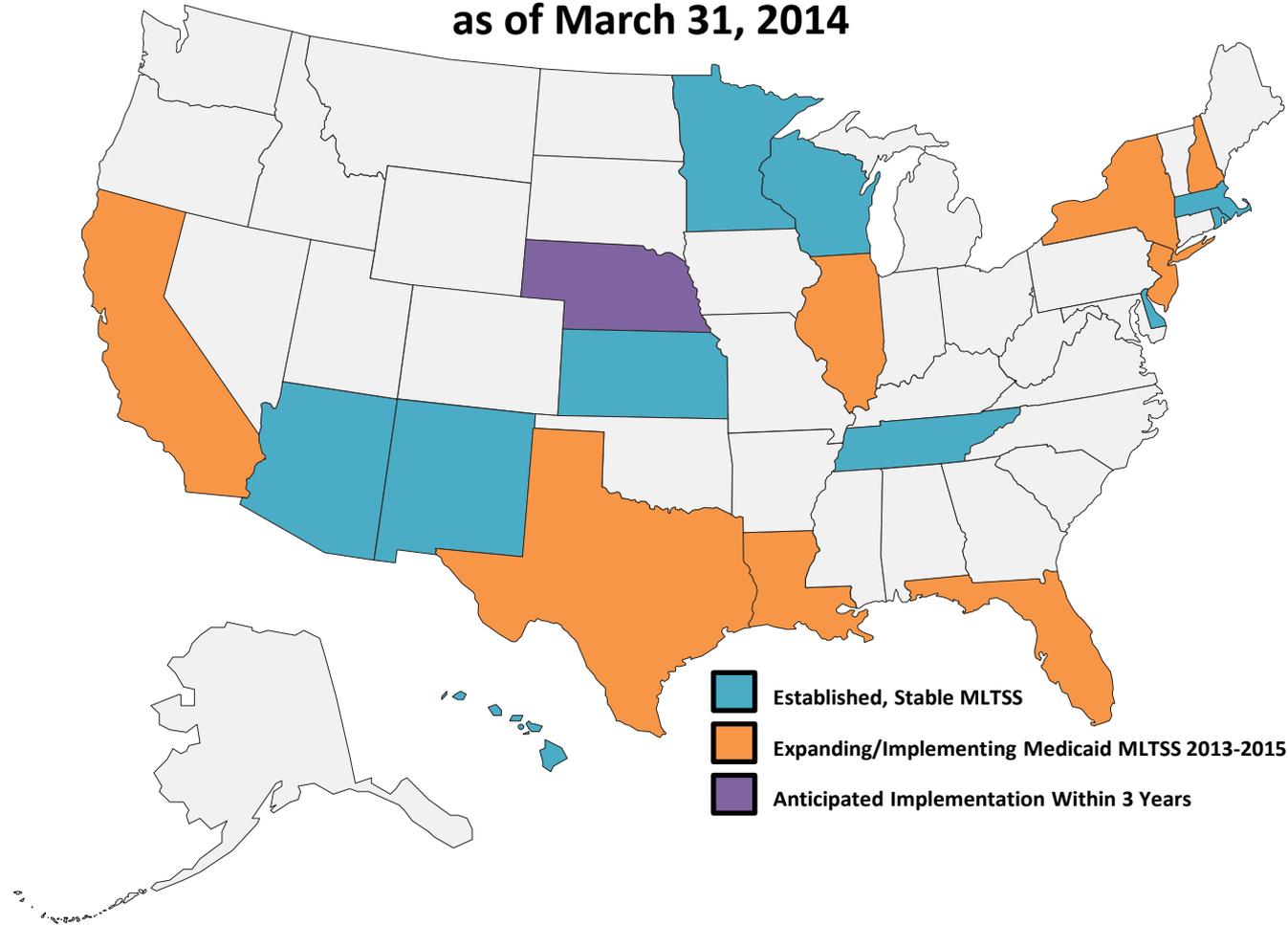
Managed Care Overview

- In a recent Kaiser 50-state survey, it was reported that nearly all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings
- A total of 39 states (28 in FY 2013 and 25 in FY 2014) specifically reported a policy change or initiative to expand managed care, or to improve care coordination
- In addition to managed care, new or expanded care coordination efforts were underway in 40 states (25 states in FY 2013 and 33 states in FY 2014). These initiatives include implementation of health homes, patient-centered medical homes, and Accountable Care Organizations

Medicaid Managed Long Term Supports and Services (MLTSS) Status as of March 31, 2014



Medicaid Managed Long Term Supports and Services (MLTSS) Status as of March 31, 2014



Use of Managed Care in Medicaid

- State Medicaid programs continue to increase their reliance on managed care citing that managed care provides significant benefits, including assuring access to services, a structure to measure and improve quality, and a reduction in program costs:
 - Improved care coordination
 - Utilization management strategies

Use of Managed Care in Medicaid

- As Medicaid managed care continues to expand the goals remain clear:
 - Improved access to primary care and medical homes
 - Improved management of chronic conditions
 - Diversion from emergency rooms and avoidable inpatient admissions
 - Improved management of hospital stays and prevention of readmissions

Inclusion of I/DD Services and Supports in Managed Care

- As states continue to expand the use of managed care for their Medicaid programs, persons with ID/DD, and specifically waiver programs once carved out of managed care arrangements, are a growing group being considered for participation
- In addition, some states are choosing to expand more broadly, in some cases placing *all* Medicaid programs and populations into a single contract with one or more MCOs, with Medicaid enrollees no longer have the option to “opt out” of managed care arrangements

Inclusion of I/DD Services and Supports in Managed Care

- Advocates routinely raise the following concerns about inclusion of persons with ID/DD in managed care:
 - Adequate numbers of specialty providers in MCO provider networks
 - Potential loss of relationships with existing providers
 - Restrictions on DME and supplies due to UM strategies
 - Loss of control, particularly among persons who self-direct services
 - Lack of understanding of the service delivery system and its values and driving principles for care delivery

Inclusion of I/DD Services and Supports in Managed Care

- Provider concerns about inclusion of person with I/DD in managed care include:
 - Fear of payment/rate reduction, inadequate funding to adequately serve individuals
 - Loss of control of how services are delivered
 - How to manage programs under managed care arrangement
 - Loss of connection to individuals being served

WHAT ARE THE GOALS OF “MANAGED CARE” FOR INDIVIDUALS WITH I/DD?

Managed Care for Individuals with I/DD

- Better care coordination across full health care spectrum
- Better access to services
- Better quality oversight
- Budget stability
- Improved outcomes

HEALTH CARE COORDINATION

Better Care Coordination

- There is currently very little care coordination in I/DD systems, particularly health care coordination
- Often times the path to health services is through emergency room
- In most locations hospitals don't know who the I/DD providers are and have no relationship with them
- As hospitals seek to reduce emergency room admissions/re-admissions they are being forced to identify high utilizers
- Approximately two-thirds of I/DD population is dually eligible for Medicaid and Medicare and many are high emergency room utilizers

Better Care Coordination

- Hospitals and physicians are incentivized/penalized for re-admission rates, but they have little to no control over who comes into ED
- I/DD providers, as well as other long-term services and supports providers have a large population impacting hospital metrics
 - Yet there is little to no relationship in most cases
- The incentives/penalties are misplaced to see true reform in this area for these populations...

Better Care Coordination

- Can managed care solve this?
- If a managed care program is set up appropriately there could be work done through managed care to help solve this, BUT...
- As managed care programs for I/DD are currently being contemplated it does not seem there will be much push for change
- There needs to be cross-provider-level penalties/incentives in order to achieve desired outcomes, including both Medicaid and Medicare

Better Care Coordination

- One state example to highlight the need for inclusion of Medicare incentives to achieve true reform for individuals with I/DD
- Duals – 10,177 (62%) of I/DD population, \$12.4 million (20%) Medicaid non-LTSS spend
- Non-Duals – 6,332 (38%) \$50.2 million (80%) Medicaid non-LTSS spend
- The duals are 62% of the population in this particular state, yet only account for 20% of non-LTSS spend (hospital, pharmacy, dental, etc.). A large percentage of the health care expenditures are not being captured and any savings achieved only benefits the Medicare provider, particularly in an ACO arrangement

Better Care Coordination

- Current efforts underway to solve these problems:
 - Separate from duals demonstrations (which typically carve out individuals with I/DD) there is a provider-level movement beginning to take shape to solve this problem
 - In at least one state providers across the Medicaid services spectrum (I/DD, Nursing Facility, Home Health, Mental Health, Hospitals and Physicians) have come together to begin discussing ways to coordinate better under current regulatory structures as well as what a future State program could look like to maintain and support better care coordination
 - Under the current environment providers are looking at the following:

Better Care Coordination

- Partnering with an ACO
 - Creating a shared savings agreement with an ACO to realize some of the Medicare savings
 - In at least one instance a provider was able to drop the re-admission rate of their facility to zero
 - This was done by creating a partnership with the ACO
- Partnering directly with hospitals
 - As data is being shared between providers the impact of individuals with I/DD on ED readmission rates is beginning to come together
 - One hospital and I/DD provider are working on a partnership strategy whereby the hospital will provide a nurse practitioner and an access line for service prior to going to ED

Better Care Coordination

- Managed care opportunities
 - More flexibility in creating cross-provider incentivization for better care coordination
 - Centralized point of coordination of fragmented services
 - Improved health outcome achievement and measurement
 - Many providers are creating the necessary relationships and environment to maximize the opportunity

HCBS SERVICES

HCBS Services

- Most states' current construct for home and community based services (HCBS) for individuals with I/DD is through a 1915 (c) waiver
 - Fee-for-service payment structure
 - Assessment and resource allocation methodology
 - Person-centered planning process
 - Service delivery
 - Case management/service coordination
 - Residential habilitation
 - Day habilitation services (community & facility based)
 - Therapies
 - Other ancillary services (varies by state)
 - Many states maintain a waiting list for services

HCBS Services

- High utilization rates and very little outcome measurement
- States typically see 94%-95% utilization rate in instances of quarterly or hourly service reimbursement
- 100% utilization of allocation in some instances of daily rate structure
- Residential habilitation is largest service

HCBS Services

- There is a strong push to measure outcomes but States are struggling to identify appropriate measures and methodologies
- There is no link between payments and outcome attainment
- Increasing employment rate and employment opportunities is the top outcome priority for most individuals with I/DD and states
- Person-centered plan is created annually, but there is no tie to the plan and progress towards achieving goals in the plan. This can create a cycle of “habilitative” stagnation

HCBS Services

- The managed care opportunities for HCBS services include:
 - More flexibility to create outcome incentives and achieve better individual and system outcomes
 - Create a link between person-centered plan and progress towards an individuals goals, both short-term and long-term
 - Create a flexible payment arrangement to providers to allow for maximum creativity in delivering services

INSTITUTIONAL SERVICES

Institutional Services

- Most states still operate institutions for individuals with intellectual and developmental disabilities
 - Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD)
- On average ICF/IDDs are 2-3 times more expensive on a per capita basis than HCBS settings
- There is a large push at the federal and state level to maximize independence and shift away from unnecessary institutional care
 - Balancing Incentive Payment Program
 - Money Follows the Person
- There still remains resistance and debate over the need and use of ICF/IDDs within the service delivery system

Institutional Services

- The managed care opportunities include:
 - More flexibility to incentivize deinstitutionalization efforts
 - Opportunity to realize cost savings and reinvest in other areas of the system
 - Managed care assessments could offset institutional assessments that create financial barriers to deinstitutionalization

ADDITIONAL OPPORTUNITIES

Additional Opportunities

- Access to mental health services
 - This is an entire stand alone presentation
- Behavioral health integration
- Waiting list reduction/elimination
- Crisis services

CONCLUSION

Conclusion

- There are many models being considered by states as increased pressure from Medicaid enrollments and mounting fiscal pressures are forcing states to consider alternative care methods
- “Silo’d” approach to service delivery no longer viable
- CMS and states are increasingly looking to coordinating services between provider types (hospitals, community providers, CMHCs, nursing facilities, etc.)
- Providers need to become more proactive in working with state officials to craft public policy
- New and interesting models of care across all populations will continue to emerge in the coming years

Conclusions

- Any I/DD managed care program needs to be individualized and person-centered
- I/DD systems present many opportunities for positive change through managed care
- There is a fear factor related to managed care that the residential and community-focused services will be built into a “medical model” of care
- Managed care can be done through a health plan or under a provider-driven construct with or without full-risk capitation
- Managed care for I/DD systems likely represents the next great service delivery transformation

HEALTH MANAGEMENT ASSOCIATES

Q & A

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